U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 23 March 2006

Case No. 2004-BLA-5939

In the Matter of

DEBRA L. PATTERSON,
o/b/o ESTATE OF ALVIE L. PATTERSON,

and

DEBRA L. PATTESRON, Widow of
ALVIE L. PATTERSON,

Claimants,

v.

WEST KEN CO., INC.,
c/o ANDALEX RESOURCES,

Employer,

and

OLD REPUBLIC INS. CO.,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES:[1]

---

[1] The Director, Office of Workers' Compensation Programs, a party in this proceeding, was not present or represented by counsel at the hearing. By failing to appear at the hearing and only participated in this case after its referral to this office by submitting a black lung evidence summary form, the Director is deemed to have waived any issues which it could have raised

Thomas M. Rhoads, Esq.
Rhoads & Rhoads, PSC
Madisonville, Kentucky
For the Claimants

John T. Chafin, Esq.
Law Offices of Chafin & Davis
Prestonsburg, Kentucky
For the Employer/Carrier

BEFORE: DANIEL J. ROKETENETZ
Administrative Law Judge

DECISION AND ORDER –
DENIAL OF MINER'S BENEFITS ON REMAND
AND DENIAL OF SURVIVOR'S BENEFITS

These consolidated cases arise from two claims for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977 ("Act"), 30 U.S.C. § 901 et seq., and the regulations issued thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

On October 31, 2002 and March 10, 2004, these cases were referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a hearing. (MDX 81; WDX 27).[2] A formal hearing in these matters was conducted on April 20, 2005, in Madisonville, Kentucky, by

---

at any stage prior to the close of this record. By referring this matter for hearing the Director is further deemed to have completed evidentiary development and adjudication as required by the regulations. 20 C.F.R. § 725.421.

[2] In this Decision and Order, "MDX" refers to the Director's exhibits in the Miner's claim, "WDX" refers to the Director's exhibits in the Widow's claim, "MEX" refers to the Employer's exhibits in the Miner's claim, "MCX" refers to Claimant's exhibits in the Miner's claim, "WEX" refers to the Employer's exhibits in the Widow's claim, "WCX" refers to Claimant's exhibits in the Widow's claim, and "TR" refers to the transcript of the hearing.

Administrative Law Judge Robert L. Hillyard. On December 30, 2004, the cases were transferred to the undersigned due to Judge Hillyard's pending retirement. All parties were afforded full opportunity to present evidence as provided in the Act and the regulations issued thereunder. Based upon a thorough analysis of the entire record in these cases, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History:

The Miner, Alvie Patterson, filed his application for federal black lung benefits on August 26, 1998 which was assigned case number 1999-BLA-0980. (MDX 1). The District Director awarded benefits on January 8, 1999. (MDX 18). After reviewing additional evidence, the Director affirmed the original finding on May 5, 1999. (MDX 27). The Employer requested a formal hearing, and the case was transferred to the Office of Administrative Law Judges. (MDX 30, 39). Administrative Law Judge Donald W. Mosser denied benefits on October 4, 2000. (MDX 56). The Miner appealed to the Benefits Review Board ("Board"). (MDX 57). On October 22, 2001, the Board affirmed in part, vacated in part, and remanded the claim. (MDX 65).

As Judge Mosser had retired, the case was reassigned to Administrative Law Judge Thomas F. Phalen, Jr. (MDX 67, 70). After the Employer submitted a motion to re-open proof on February 25, 2002, Judge Phalen mistakenly characterized this as a request for modification. (MDX 68, 70). Judge Phalen re-opened the record and remanded the case to the District Director for further development of evidence on March 25, 2002. (MDX 70).

While the claim was pending before the District Director, the Miner died on February 17, 2002. (MDX 74). The Director substituted Debra Patterson, the Miner's widow, as the Claimant on behalf of the Estate of Alvie Patterson, the case was re-numbered 2003-BLA-0032. (MDX 75). Also, the Director notified Mrs. Patterson that she was entitled to file a survivor's claim. Id. She did so on June 2, 2002; however, her claim was not consolidated with her husband's claim. (WDX 2). The District Director denied the Miner's claim on July 11, 2002. (MDX 77). Acting on behalf of her husband's estate, Mrs. Patterson requested a formal hearing in the Miner's claim, and the case

was transferred to the Office of Administrative Law Judges. (MDX 78, 80-81). At a formal hearing on May 13, 2003, Administrative Law Judge Joseph E. Kane continued the case for further development of the record. The case was reassigned to the undersigned and scheduled for a hearing on December 16, 2004 in Madisonville, Kentucky. The Employer filed a motion to consolidate the Miner's and Survivor's claims. On September 22, 2004, I issued an Order remanding the claim for consolidation. In a memorandum from a claims examiner with the District Director dated October 29, 2004, it was noted that the Survivor's claim was already pending before Administrative Law Judge Robert L. Hillyard, and the Miner's claim was being returned to this office.

Mrs. Patterson's claim was denied by the District Director on October 30, 2003. (WDX 20). She requested a formal hearing, and the case was transferred to the Office of Administrative Law Judges. (WDX 21, 27). As such, the Miner's and Survivor's claims have been consolidated.

Miner's Claim:[3]

On October 22, 2001, the Board affirmed in part, vacated in part, and remanded the Miner's claim for further consideration consistent with its Decision.[4] (MDX 65). Specifically, the Board ordered that the administrative law judge's findings under Section 781.202(a)(4) were vacated, and on remand, the administrative law judge was to set forth his basis for finding opinions reasoned and documented as well as the credibility assigned to each physician, including the Miner's treating physician, Dr. Canonico. Additionally, the Board affirmed the administrative law judge's findings under Section 718.204(c)(2000). (MDX 65, p. 3, n. 3). However, at the end of the Board's opinion, the administrative law judge's findings under § 718.204(b)(2000), regarding the definition of total disability, were vacated. As Judge Mosser made no findings with respect to the definition of total disability under

[3] Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations. Amendments to the Part 718 regulations became effective on January 19, 2001. Section 718.2 provides that the provisions of Section 718 shall, to the extent appropriate, be construed together in the adjudication of all claims.

[4] The issues in the Miner's claim that were not contested or that were affirmed by the Board will not be addressed herein.

§ 718.204(b)(2000) and the Board previously affirmed his determination of total disability under § 718.204(c)(2000), I will not address this issue herein.

The Findings of Fact and Conclusions of Law contained in Judge Mosser's previous Decision and Order are hereby adopted in this Decision and Order on Remand except to the extent that any findings made in the previous Decision is inconsistent with the findings and conclusions expressed in this Decision and Order on Remand. Furthermore, on remand, Judge Phalen re-opened the record. Accordingly, additional evidence submitted relating only to proof of pneumoconiosis under Section 781.202(a)(4) will also be considered.[5] Newly offered evidence that does not relate to this section will not be addressed herein.

Pneumoconiosis:

Section 718.202(a) sets forth four alternate methods for determining the existence of pneumoconiosis. Establishing the existence of pneumoconiosis as is set forth in Section 718.202(a)(4) is contested. This subsection provides for such a finding where a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis. Any such finding shall be based upon objective medical evidence and shall be supported by a reasoned medical opinion. A reasoned medical opinion is one which contains underlying documentation adequate to support the physician's conclusions. Field v. Island Creek Coal Co., 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id.

In reviewing the medical reports examined by Judge Mosser, Dr. Bradham examined the Miner during an emergency room visit. (MDX 14). She opined that the Miner had an interstitial lung disease due to his coal mine employment. Although she noted the Miner had previously smoked and worked in the coal mine industry, she did not list exact histories. It is proper for an administrative law judge to discredit a medical opinion based on an inaccurate length of coal mine employment. Worhach v. Director, OWCP, 17 B.L.R. 1-105 (1993)(per curiam) (physician reported an eight year coal mine employment history, but the

[5] Exhibits MCX 1-9 and MEX 1-8 were offered into evidence at the May 13, 2003 hearing before Judge Kane, and Exhibits MEX 9-12 were offered into evidence at the April 20, 2005 hearing before Judge Hillyard.

administrative law judge only found four years of such employment); Trumbo v. Reading Anthracite Co., 17 B.L.R. 1-85 (1993) (physician's opinion less probative where based on inaccurate smoking history). Accordingly, I grant less weight to Dr. Bradham's opinion because she did not did not base her determinations on accurate smoking and coal mine histories.

Dr. Canonico, the Miner's treating physician, examined him on August 6, 1998. (MDX 13). He noted consistent smoking and coal mine work histories. Dr. Canonico recorded fine inspiratory crackles in the lower lobes bilaterally with clubbing in the Miner's extremities. He diagnosed the Miner with interstitial lung disease. Dr. Canonico examined the Miner again on September 8, 1998. He indicated that pulmonary function studies did not indicate an obstruction, but showed a severe restrictive lung disease. (MDX 15). He diagnosed the Miner with interstitial fibrosis and opined the disease is secondary to his occupation as a miner. Furthermore, in records from Holland Medical Equipment dated September 9, 1998, Dr. Canonico diagnosed the Miner with chronic obstructive pulmonary disease and pulmonary fibrosis. (MDX 13).

In a letter prepared by Dr. Canonico, he stated that he had treated the Miner from August 1998 to the September 17, 1999, the date of the letter. (MDX 42). He explained that x-rays demonstrated changes consistent with interstitial fibrosis. Additionally, he relied on a CT scan which indicated right hilar and mediastinal adenopathy as well as pulmonary fibrosis with subpleural interstitial coursing and early honeycombing. He also noted that transbronchial biopsies showed mild, chronic bronchitis with very mild, patchy interstitial fibrosis. Dr. Canonico reported that the mediastinoscopy showed the lymph nodes had silicoanthrocotic nodule formation and the lung biopsies demonstrated interstitial fibrosis. In conclusion, Dr. Canonico opined that the Miner's lung disease was due to the Miner's coal mine employment. I find that Dr. Canonico's opinion is well-reasoned and well-documented.

Dr. Traughber's opined that the Miner had category 1/1 pneumoconiosis and a restrictive ventilatory deficit due to coal dust exposure. Dr. Traughber based his findings on a positive x-ray, a pulmonary function study that was invalidated, symptomatology, and coal mine and smoking histories consistent with Judge Mosser's findings. As noted by Judge Mosser, I find Dr. Traughber's report is well-reasoned and well-documented.

Dr. Taylor, Board-certified in Internal Medicine and Pulmonary Diseases, examined the Miner on October 9, 1998. (MDX 15). He noted that an x-ray showed calcified granuloma which could represent coal workers' pneumoconiosis and/or other superimposed diseases. He also performed a pulmonary function study and arterial blood gas analysis, as well as noting rales on the Miner's chest examination. Dr. Taylor examined the Miner three more times and reviewed medical testing and reports from Drs. Traughber and Canonico. (MDX 42). He chronicled this information in his February 29, 1999 medical report where he opined the Miner had pulmonary fibrosis due to inhalation of coal dust. Dr. Taylor specifically relied on abnormal pulmonary function tests and CAT scans. In a third report, Dr. Taylor opined the Miner had chronic lung disease which he listed as coal workers' pneumoconiosis as shown by fibrotic lung disease on CAT scans. He agreed with Dr. Branscomb's finding that the miner's lung problems were caused by a fibrotic pattern in his lungs, but he believes this disease was caused by coal dust exposure with obesity as a secondary cause. (MDX 42). In his deposition on June 5, 2000, Dr. Taylor testified that the Miner was obese which could have caused his restrictive pattern on his pulmonary function studies. (MDX 43). As noted by Judge Mosser, I find Dr. Taylor's opinion is well-reasoned and well-documented.

Dr. Branscomb, Board-certified in Internal Medicine and Pulmonary Diseases, prepared a consultative report on October 4, 1999 after examining the medical evidence of record. (MDX 43). Dr. Branscomb opined that the Miner did not have coal workers' pneumoconiosis. He stated the Miner has an interstitial pulmonary disorder, but it is not caused by coal mine employment nor is it severe. Dr. Branscomb explained that even if he assumed the x-rays he reviewed were positive, he asserted that his findings are the result of obesity and non-occupational factors including gastroesophageal reflux. In his deposition, Dr. Branscomb reiterated his initial findings. (MDX 43). Also, he stated that the Miner had a restrictive component which is more prevalent in breathing problems caused by exposure to coal dust. However, he concluded that the Miner did not have coal workers' pneumoconiosis, but the lung biopsy did show minimal evidence of fibrosis. As Dr. Branscomb was able to review extensive medical opinions and objective testing and he offered explanations for the Miner's condition, I find his report is well-reasoned and well-documented as stated in Judge Mosser's decision.

Dr. Dahhan, Board-certified in Pulmonary Diseases and Internal Medicine, prepared a consultative report on October 5, 1999. (MDX 43). He stated that there were insufficient findings to justify a diagnosis of coal workers' pneumoconiosis, specifically as shown by negative x-rays, negative CT scans, and pathological evidence. Dr. Dahhan did opine that the Miner had interstitial pulmonary fibrosis, but that it is a disease of the public at large and is not caused by or contributed to by coal dust or coal workers' pneumoconiosis. At his deposition on March 20, 2000, Dr. Dahhan further explained that the Miner's interstitial fibrosis is called Hamman Rich disease, which is a form of interstitial fibrosis with no specific etiology. (MDX 43). Dr. Dahhan testified that the Miner did have some coal dust in his lungs, but it did not cause the reaction of the lungs. As noted in Judge Mosser's decision and based on the medical evidence noted above, I find Dr. Dahhan's opinion is well-reasoned and well-documented.

Dr. Fino, Board-certified in Internal Medicine and Pulmonary Diseases, prepared a consultative report on October 6, 1999. (MDX 43). He opined the Miner did not have an occupationally acquired pulmonary condition as a result of coal dust exposure as shown through pulmonary function studies. After reviewing x-rays and CT scan's, Dr. Fino concluded that there were no parenchymal abnormalities consistent with pneumoconiosis or any other occupational lung disease associated with coal mine dust. In his deposition testimony on March 17, 2000, Dr. Fino stated that his findings remained unchanged. I find his report is well-reasoned and well-documented as listed in Judge Mosser's decision.

On February 29, 2000, Dr. Hansbarger performed a consultative review of the medical evidence. (MDX 43). After reviewing the pathology slides, he noted that the lung shows anthracotic pigment with focal reactive fibrosis. He diagnosed transbronchial biopsy of the lung showing bronchitis, pulmonary parenchyma with evidence of anthracotic pigmentation and focal fibrosis tissue proliferation. However, he explained that he could not make a definite diagnosis of occupational pneumoconiosis because the amount of material present in the lung is very minute. He noted that his finding was supported by the majority of reports of record. Accordingly, as Judge Mosser determined, I find Dr. Hansbarger's report is well-reasoned and well-documented.

Dr. Caffrey, a Board-certified Pathologist, prepared a consultative report on February 19, 2000. (MDX 43). On reviewing

the pathology slides, Dr. Caffrey's findings included no specific pathology, very minimal, focal interstitial fibrosis, and focal, mild amount of very anthracotic pigment identified. After examining the medical records, Dr. Caffrey concluded that he cannot make a diagnosis of coal workers' pneumoconiosis, silicosis, or any other occupational pneumoconiosis. Furthermore, he stated that the pathology slides did not show pulmonary fibrosis. At his deposition on March 28, 2000, Dr. Caffrey explained that although the Miner had anthracotic pigment in his lungs that a disease had not occurred in the lungs due to the pigment. He testified that the findings in his report remained unchanged. I find his opinion is well-reasoned and well-documented as noted by Judge Mosser.

An August 14, 1998 CT scan was interpreted by Dr. Addleston at St. Thomas Hospital. (MDX 13). He noted that the pulmonary parenchymal changes are typical of interstitial fibrosis. He also listed emphysematous change bilaterally. Dr. Addleston explained subpleural interstitial coarsening and early honeycombing on the high resolution CT of the chest. He explains that this was most likely a reflection of pulmonary fibrosis and only mild peribronchial interstitial thickening is present. This CT was also interpreted by Dr. Branscomb, and he found no coal workers' pneumoconiosis as shown by the lack of diffuse regular or irregular nodules. (MDX 43). Additionally, Dr. Wheeler re-read the CT scan. Id. He stated there was no evidence of silicosis or coal workers' pneumoconiosis. He noted in his report that the small scattered areas of linear and irregular interstitial fibrosis or infiltrates in the periphery of both lungs is interstitial pneumonia or other idiopathic peripheral lung disease.

This concludes the medical evidence summarized in Judge Mosser's decision regarding pneumoconiosis under § 718.202(a)(4). On remand from the Board, Judge Phalen allowed the record to be re-opened. The following evidence has been submitted into the record at the hearings conducted by Judges Kane and Hillyard.

Treatment notes from St. Thomas Medical Group were submitted into evidence. (MCX 1, 7). The Miner was treated from October 6, 1999 to February 7, 2002. Physical examinations showed diffuse lung crackles, and a CT scan showed mild enlargement of the mediastinal nodes and right hilar adenopathy with severe interstitial pulmonary fibrosis with honeycombing. (MCX 4). Pulmonary function studies were essentially normal. (MCX 2, 8). Cytology reports were normal also. (MCX 7). Numerous

x-rays were taken and showed very little change in condition; however, these x-rays readings were not attached. Various diagnoses for the Miner included interstitial pulmonary fibrosis secondary to occupational exposure followed by end-stage interstitial pulmonary fibrosis, hypoxemia, cystic fibrosis, obesity, and bronchitis. The remainder of the findings in the treatment notes do not relate to the Miner's respiratory or pulmonary condition. The physicians who made diagnoses listed in these treatment notes did not expressly state the medical evidence that they relied on in making their determinations. Therefore, I find the diagnoses in the treatment notes form St. Thomas Medical Group are unreasoned.

Hospital records from St. Thomas Hospital dating from December 7, 2001 to December 10, 2001 were offered into evidence. (MCX 3). In the admitting report, Dr. Canonico noted the Miner quit smoking forty years earlier and had not worked in the coal mining industry for thirty years. A chest examination showed diffuse bilateral crackles with the lower lobes greater than the upper lobes and the left greater than the right. Dr. Canonico's impression was interstitial pulmonary fibrosis, worsening hypoxemia, shortness of breath, and episodes of hemoptysis. Due to the Miner's chest x-ray and off-colored sputum, Dr. Canonico opined the Miner could have a pneumonic process superimposed on his interstitial fibrosis. He admitted the Miner to the hospital for evaluation. Cytology reports and a bronchoscopy were normal.

The Miner was treated at Regional Medical Center on February 17, 2002. (MCX 5).[6] A chest x-ray read by Dr. Trover stated "there is cardiomegaly and prominence of the pulmonary vasculature. I think there are infiltrates present. The appearance is that of pulmonary edema. The congestive findings are increased compared to film from January 4." Several of the treatment notes were illegible; however, Dr. Hanke noted that the Miner had end-stage pulmonary fibrosis and was terminal. Later in the day, the Miner died, and in a death summary, Dr. Hanke listed the cause of death as pulmonary fibrosis.

In a letter to the Claimant's attorney dated April 23, 2003, Dr. Canonico stated that his consistent pulmonary diagnosis was interstitial pulmonary fibrosis caused by the

[6] An autopsy report was submitted; however, the Board previously affirmed findings pursuant § 718.20(a)(2). (MDX 6). As this report would be evaluated under that section, it will not be considered herein because it does not qualify as medical report.

Miner's occupational exposure to coal and rock dust over a period of fifteen years. (MCX 9). Specifically, Dr. Canonico stated that he relied on chest x-rays, breathing tests, and CT scans which all indicated pulmonary fibrosis. He was able to make this determination because mixed connective tissues were negative, there were no physical presentations for another possibility, and he was the wrong age and gender to develop idiopathic pulmonary fibrosis. Thus, given his coal dust exposure and lack of any smoking history for the past several years, Dr. Canonico attributed the disease to his occupational history. In conclusion, Dr. Canonico opined the Miner suffered form a chronic lung disease primarily caused by his fifteen years of exposure, and he was able to reach this conclusion with an autopsy report showing clinical pneumoconiosis.

In viewing all of Dr. Canonico's medical reports, hospital and treatment notes together, I find his opinion is well-reasoned and well-documented. However, I note that other physicians in the record were afforded the opportunity to examine extensive medical evidence in forming their conclusions, and Dr. Canonico treated the Miner less than four years at which time other physicians of record were familiar with the Miner's condition. Furthermore, Dr. Canonico's medical qualifications were not offered into evidence while other physicians that examined the Miner are Board-certified specialists. Although Dr. Canonico's opinion is well-reasoned and well-documented, I decline to automatically grant his opinion more weight simply because he is the Miner's treating physician. His opinion will be entitled the same weight as the other well-reasoned and well-documented opinions of record. See Eastover Mining Co. v. Williams, 338 F.3d 501 (6th Cir. 2003) (holding that the opinion of a treating physician is not automatically entitled to greater weight simply because of the physician's status); Tedesco v. Director, OWCP, 18 B.L.R. 1-103 (1994) (holding an administrative law judge "is not required to accord greater weight to the opinion of a physician based solely on his status as Miner's treating physician. Rather, this is one factor which may be taken into consideration . . .").

Dr. Caffrey prepared a consultative report dated August 27, 2002. (MEX 2). He reviewed the Miner's employment history; Dr. Bradham's treatment notes; an August 24, 1998 bronchoscopy, mediastinoscopy, and an operative reports; Dr. Canonico's September 8, 1998 report; Dr. Traughber's September 24, 1998 medical report; Dr. Taylor's October 9, 1998 medical reports with follow-up reports dated January 5, 1999 and September 2, 1999; a letter addressed to the Miner from Dr. Taylor dated

September 24, 1999; a letter from Dr. Canonico dated September 17, 1999; a surgical pathology report from St. Thomas Hospital; his own consultative report prepared on February 19, 2000; Dr. Hansbarger's February 29, 2000 medical report; copies of sixteen chest x-rays; one copy of a CT scan interpretation; the Miner's death certificate; an autopsy report by Dr. Bauer; and, twelve autopsy slides dated February 18, 2002.

Dr. Caffrey noted the Miner had a coal mine employment history of fourteen years, and he previously smoked from ages sixteen to twenty-two. Dr. Caffrey stated "[i]t is my opinion from a review of these records, the previous records, including my previous report, the autopsy report and autopsy slides that Mr. Alvie Patterson did not have coal workers' pneumoconiosis, did not have silicosis, and did not have any other occupational lung disease." He did concede that the autopsy slides showed a minimal amount of anthracotic pigment, but there were no lesions of coal workers' pneumoconiosis or silicosis. However, Dr. Caffrey did diagnose idiopathic pulmonary fibrosis with similar findings in both lungs. He cited to the textbook DAIL AND HAMMER, PULMONARY PATHOLOGY, 647 (2nd ed.), where the authors state that "[m]ore than 100 known causes of interstitial lung disease are recognized and most are associated with some degree of interstitial fibrosis. In approximately two-thirds of cases, the cause is unknown and the morphogensis is poorly understood." Accordingly, Dr. Caffrey opined that he did not know what caused the Miner's bilateral pulmonary fibrosis. However, because the autopsy slides did not show mixed-dust fibrosis, he stated that his coal mine employment did not cause the disease. At his June 29, 2004 deposition, Dr. Caffrey testified to the same findings. (MEX 12). In viewing his February 19, 2000 medical report, in conjunction with the current report and his deposition, I find Dr. Caffrey's opinion is well-reasoned and well-documented.

Dr. Broudy, Board-certified in Internal Medicine and Pulmonary Diseases, prepared a consultative medical report dated March 10, 2003. (MEX 3). He reviewed x-ray readings by Drs. Kendall, Branscomb, Fino, Wheeler, Dahhan, Baker, Binns, Abramowitz, Baek, Barrett, Sargent, and Traughber; the Miner's death certificate; Dr. Taylor's October 9, 1998 and September 24, 1999 medical reports; Dr. Canonico's September 17, 1999 letter; Dr. Dahhan's October 5, 1999 medical report; Dr. Branscomb's October 4, 1999 medical report; Dr. Fino's October 6, 1999 medical report; Dr. Traughber's September 24, 1998 medical report; a CT scan read by Drs. Branscomb, Fino, and Wheeler; Dr. Hansbarger's report including pathology findings; and Dr. Caffrey's reports reviewing autopsy and biopsy slides.

Based on the above-listed information, Dr. Broudy opined that the Miner did not have coal workers' pneumoconiosis; however, he did suffer from idiopathic interstitial pulmonary fibrosis. He did not list any etiology for his determination.

In a supplemental report dated May 1, 2003, Dr. Broudy reviewed Dr. Canonico's April 23, 2003 report. (MEX 7). He explained that Dr. Canonico did not review any additional evidence but merely offered his opinion for the previous abnormalities. Dr. Broudy expressly disagreed with Dr. Canonico's findings because they were unsupported by the Miner's autopsy and pathology reports and the presence or absence of smoking was of little importance. In conclusion, Dr. Broudy stated that his opinion remained unchanged from his March 10, 2003 letter. In viewing his reports together, I find Dr. Broudy's opinion is well-reasoned and well-documented.

On March 17, 2003, Dr. Dahhan, Board-certified in Internal Medicine and Pulmonary Disease, prepared a consultative medical report. (MEX 4). Dr. Dahhan reviewed his own medical report and objective medical testing dated October 5, 1999; the Miner's death certificate; Dr. Hansbarger's February 29, 2000 medical report; Dr. Caffrey's August 22, 2002 and September 10, 2000 medical reports; Dr. Kendall's reading of a September 24, 1998 x-ray; Dr. Branscomb's x-ray interpretations; Dr. Fino's x-ray interpretations; an August 14, 1998 x-ray interpreted by Drs. Fino and Wheeler; Dr. Lancaster's February 7, 2002 treatment notes; depositions from Drs. Branscomb, Fino, Caffrey, Taylor, and himself; his own x-ray readings; a letter from Dr. Canonico dated September 17, 1999; and two reports from Dr. Taylor. Based on this information, he opined that the Miner did not have coal workers' pneumoconiosis as shown by autopsy evidence. However, he did state the Miner had interstitial lung disease which was the variety of "usual interstitial lung disease or Hamman Rich Syndrome." Dr. Dahhan concluded by stating that based on the entire medical record, the Miner had no evidence of coal dust induced lung disease. At his April 11, 2003 deposition, Dr. Dahhan testified to the same. (MEX 6).

In a supplemental report dated June 9, 2003, Dr. Dahhan reviewed Dr. Caffrey's medical report, Trover Clinic treatment records, St. Thomas Hospital records, Dr. Hanke's death summary, his own report, and treatment records and medical reports from Dr. Canonico. (MEX 10). Based on the information that he reviewed, Dr. Dahhan continued to conclude that the Miner did not have coal workers' pneumoconiosis, nor was his death caused by the disease. In viewing his October 5, 1999 medical report in

conjunction with the current reports and his deposition, I find Dr. Dahhan's opinion is well-reasoned and well-documented.

Dr. Fino, Board-certified in Internal Medicine and Pulmonary Diseases, prepared a consultative report on March 28, 2003. (MEX 5). He reviewed x-ray interpretations by Drs. Branscomb, Kendall, Dahhan, Wheeler, Baker, Canonico, Barrett, Goldstien, Sargent, Traughber, Abramowitz, Baek, Binns, and Taylor; clinic treatment notes from January 5, 1999 to September 2, 1999; an August 14, 1998 CT scan; Dr. Canonico's September 17, 1999 medical letter; Dr. Taylor's September 249, 1999 medical letter; Dr. Branscomb's October 4, 1999 medical report; Dr. Dahhan's October 5, 1999 medical report; Dr. Caffrey's February 19, 2000 pathology report; Dr. Hansbarger's February 29, 2000 pathology report; depositions from Drs. Branscomb, Fino, Dahhan, Caffrey, Taylor; Dr. Taylor's March 27, 2000 questionnaire; cytology reports; Dr. Canonico's February 7, 2002 progress note; the Miner's death certificate; and Dr. Caffrey's August 27, 2002 medical report. From this evidence, Dr. Fino opined the Miner did not have clinical pneumoconiosis as shown through pathology reports. However, Dr. Fino did diagnose the Miner with idiopathic interstitial pulmonary fibrosis. He stated that this disease was not contributed to or caused by coal dust exposure as shown by no advanced silicosis or heavy anthracotic dust deposition in the lungs. He explained that the Miner's exact cause of death was unknown because the autopsy was limited to the lungs.

In a supplemental report dated May 6, 2003, Dr. Fino reviewed Dr. Canonico's April 23, 2003 medical report. (MEX 8). He specifically stated that there was no objective evidence of a respiratory impairment. Furthermore, Dr. Fino explained Dr. Canonico's statements that the Miner is the wrong age and gender to develop idiopathic pulmonary fibrosis are incorrect. In viewing his October 6, 1999 medical report in conjunction with the current reports, I find Dr. Fino's opinion is well-reasoned and well-documented.

On June 8, 2003, Dr. Naeye, Board-certified in Anatomical and Clinical Pathology, prepared a consultative medical report. (MEX 9). He reviewed hospital and treatment notes from St. Thomas Hospital, St. Thomas Medical Group, and Trover Clinic. He also received medical information and consultative reports from Drs. Canonico, Sargent, Schulttenover, Addleston, Traughber, Taylor, Gallo, Baek, Abramowitz, Binns, Goldstein, Branscomb, Fino, Wheeler, Lancaster, Hanke, Davis, Caffrey, and Hansbarger. He also examined depositions from Drs. Taylor, Caffrey, Dahhan,

Fino, and Branscomb. Dr. Naeye noted that the Miner worked as a rock and coal driller for ten years, then he was a driller in a strip mine from 1977 until 1981. Also, the Miner smoked several cigarettes a day for six years, quitting at age twenty-two. Based on the evidence reviewed, Dr. Naeye concluded that the medical evidence to make a diagnosis of coal workers' pneumoconiosis was absent in the Miner. He specifically relied on the lack of focal emphysema and fibrosis admixed with black pigment. Dr. Naeye explained that the tiny amounts of black pigment seen in the Miner's lungs were no more frequent or larger than such deposits in the lungs of many non-miners. In conclusion, Dr. Naeye stated that because the Miner does not have coal workers' pneumoconiosis that the disease could not have cause any impairment or his death. I find Dr. Naeye's opinion is well-reasoned and well-documented.

Dr. Ben Branscomb, Board-certified in Internal Medicine, prepared a consultative medical report dated June 26, 2003. (MEX 11). He reviewed his prior October 4, 1999 report; Dr. Taylor's October 9, 1998 medical report; 1999 medical reports from Drs. Fino and Dahhan; Dr. Canonico's September 17, 1999 medical letter; Dr. Taylor's September 24, 1999 treatment notes; Dr. Hansbarger's February 29, 2000 report; Dr. Caffrey's February 19, 2000 medical report; Dr. Taylor's March 27, 2000 medical report; Dr. Canonico's December 10, 2001 treatment records; hospital records from St. Thomas Hospital and Dr. Lancaster; the Miner's death certificate; Regional Medical Center hospital records from Dr. Hanke dated February 17, 2002; Dr. Bauer's autopsy report; Dr. Caffrey's August 27, 2002 consultative report; Dr. Dahhan's April 11, 2003 deposition; Dr. Canonico's April 23, 2003 medical letter; pulmonary function studies contained in the medical reports; and x-ray interpretations from himself, Fino, Wheeler, Kendall, Dahhan, and Baker.

After studying the records, Dr. Branscomb found that the Miner did not have medical pneumoconiosis as shown by autopsy findings. (MEX 11). Furthermore, he stated that the pulmonary function studies and the autopsy evidence do not support a finding of chronic obstructive pulmonary disease or any obstructive disease. He explained that there was no basis for finding legal pneumoconiosis because the Miner did not have a pulmonary condition caused, irritated by, or any way aggravated by coal mine dust. However, Dr. Branscomb did diagnose the Miner with idiopathic diffuse interstitial fibrosis without any relation to his coal dust exposure. In viewing his October 4, 1999 medical report in conjunction with the current report, I

find Dr. Branscomb's opinion is well-reasoned and well-documented.

In considering the well-reasoned and well-documented medical opinions under Section 718.202(a)(4), Drs. Canonico, Traughber, and Taylor found the Miner had clinical pneumoconiosis. However, the well-reasoned and well-documented opinions of Drs. Branscomb, Dahhan, Fino, Hansbarger, Caffrey, Broudy and Naeye stated the Miner did not suffer from clinical pneumoconiosis.[7] In addition, CT scan interpretations did not indicate clinical pneumoconiosis. Based on the preponderance of the evidence, I find the Miner has not established clinical pneumoconiosis under § 718.202(a)(4).

The United States Court of Appeals for the Sixth Circuit[8] has defined clinical or medical pneumoconiosis as "a lung disease caused by fibrotic reaction of the lung tissue to inhaled dusted that is generally visible on chest x-ray films." Eastover Mining Co. v. Williams, 338 F.3d 501 (6th Cir. 2003). In contrast, "legal pneumoconiosis includes all lung diseases

---

[7] The regulations define pneumoconiosis in § 718.201 as:

> a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

Id. (2000).

Many of these physicians diagnosed the Miner with some form of fibrosis; however, none of the doctors stated the Miner had massive pulmonary fibrosis which is required for a finding of clinical pneumoconiosis.

[8] The Board has held that the law of the circuit in which the miner's last coal mine employment occurred is controlling. Shupe v. Director, OWCP, 12 BLR 1-200(1989). The Claimant's last coal mine employment took place in Kentucky, within the Sixth Circuit's jurisdiction.

meeting the regulatory definition of any lung disease that is significantly related to, or aggravated by, exposure to coal dust." Id. The Sixth Circuit previously stated "[t]his 'legal' definition of pneumoconiosis, as other circuits have noted, 'encompasses a wider range of afflictions than does the more restrictive definition of pneumoconiosis.'" Cornett v. Benham Coal Inc., 227 F.3d 569 (6th Cir. 2000) (citing Kline v. Director, OWCP, 877 F.2d 1174, 1178 (3d Cir. 1989)).

I acknowledge that the opinions of Drs. Canonico, Traughber, and Taylor qualify as both clinical and legal pneumoconiosis under the 2000 regulations. However, Drs. Branscomb, Dahhan, Fino, Caffrey, and Naeye expressly stated that the diseases that they observed were not due to the Miner's coal dust exposure. Again, I rely the preponderance of the evidence to find the Miner has not established legal pneumoconiosis under § 718.202(a)(4). As the Miner has not proven pneumoconiosis pursuant to § 718.202(a)(4), entitlement for total disability due to pneumoconiosis under § 718.204(c) need not be addressed.

Widow/Survivor's Claim:

Section 718.205 provides that benefits are available to eligible survivors of a miner whose death was due to pneumoconiosis. In order to receive benefits, the Claimant must prove that:

1. The Miner had pneumoconiosis;

2. The Miner's pneumoconiosis arose out of coal mine employment; and,

3. The Miner's death was due to pneumoconiosis as provided by this section.

Section 718.205(a).

In order to establish that a Miner's death was due to pneumoconiosis, the Claimant must establish at least one of the following criteria:

> Where competent medical evidence establishes that the miner's death was due to pneumoconiosis; or
>
> Where pneumoconiosis was a substantially contributing cause or factor leading to the

> miner's death, or where death was caused by complications of pneumoconiosis; or
>
> Where the presumptions set forth in Section 718.304 regarding complicated pneumoconiosis is applicable.

Section 718.205(c).

Because the record contains no evidence of complicated pneumoconiosis, subsection (c)(3) is inapplicable. Thus, the Claimant will recover if she can prove that the Miner died from pneumoconiosis or that pneumoconiosis substantially contributed to his death. The amended regulations provide that pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. Section 718.205(c)(5). Thus, the Claimant must prove the pneumoconiosis was the cause of Mr. Patterson's death or that it hastened his death. As the evidentiary limitations differ in the Miner's and Widow's claims, pneumoconiosis and death due thereto will be addressed.

Applicable Regulations:

Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations. Amendments to the Part 718 regulations became effective on January 19, 2001. As the survivor's claim was filed on June 2, 2002, such amendments are applicable.

The 2001 amendments significantly limit the development of medical evidence in black lung claims. The regulations provide that claimants are limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy, and two medical reports as affirmative proof of their entitlement to benefits under the Act. § 725.414(a)(2)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports and physician opinions that appear in a single medical report must comply individually with the evidentiary limitations. Id. In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary unction test, arterial blood gas study, biopsy or autopsy. §725.414(a)(2)(ii). Likewise, employers and the District

Director are subject to identical limitations on affirmative and rebuttal evidence. § 725.414(a)(3)(i, iii).

The Claimant submitted a black lung evidence summary form on April 15, 2005, and the Employer submitted its corresponding form on April 13, 2005. As this is a combined claim and the evidence in record exceeds the evidentiary limitations in the widow's claim, I will only review the evidence indicated on the parties' summary forms that complies with the above-listed limitations. The remainder of the evidence will not be addressed in the widow's claim.

ISSUES:[9]

The issues in this case are:

1. Whether the Miner had pneumoconiosis as defined in the Act and regulations;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment; and,

3. Whether the Miner's death was due to pneumoconiosis.

(WDX 27; April 20, 2005 Transcript).

Pneumoconiosis:

Section 718.205(a) requires that a survivor prove that the Miner suffered from pneumoconiosis. Additionally, in Trumbo v. Reading Anthracite Co., 17 B.L.R. 1-85 (1993), the Board held that, in a survivor's claim under Part 718, the administrative law judge must make a threshold determination as to the existence of pneumoconiosis under Section 718.202(a) prior to considering whether the miner's death was due to pneumoconiosis.

Section 718.202(a) sets forth four alternate methods for determining the existence of pneumoconiosis. Pursuant to Section 718.202, the Claimant can demonstrate pneumoconiosis by

[9] The parties stipulated to timeliness, miner, eleven years of coal mine employment, one dependent, the Claimant is a survivor, responsible operator, and the Miner's last full year of coal mine employment was with the Employer. (TR 9). The issues of total disability and causation were incorrectly marked as contested issues, as this is a survivor's claim, death due to pneumoconiosis is contested. (DX 38).

means of 1) x-rays interpreted as positive for the disease, or 2) biopsy or autopsy evidence, or 3) the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable, or 4) a reasoned medical opinion which concludes the presence of the disease, if the opinion is based on objective medical evidence such as pulmonary function studies, arterial blood gas tests, physical examinations, and medical and work histories.

Under Section 718.202(a)(1), a finding of the presence of pneumoconiosis may be based upon a chest x-ray conducted and classified in accordance with Section 718.102. To establish the existence of pneumoconiosis, a chest x-ray must be classified as category 1, 2, 3, A, B, or C, according to the ILO-U/C classification system. A chest x-ray classified as category 0, including subcategories 0/1, 0/0, or 0/-, does not constitute evidence of pneumoconiosis.

A September 24, 1998 x-ray was interpreted by Dr. Traughber as positive for pneumoconiosis with a 1/1 profusion. (MDX 12). Dr. Traughber is a B-reader.[10] The x-ray was also re-read as positive with a 1/2 profusion by Dr. Barrett who is a Board-certified Radiologist and B-reader. (MDX 14). In addition, Dr. Kendall interpreted the film as negative for pneumoconiosis. (MEX 1). Dr. Kendall is a Board-certified Radiologist and B-reader. Thus, I find this x-ray stands in equipoise; i.e., it neither proves nor disproves the existence of pneumoconiosis.

Under Part 718, where the x-ray evidence is in conflict, consideration shall be given to the readers' radiological qualifications. Dixon v. North Camp Coal Co., 8 B.L.R. 1-344 (1985). Thus, it is within the discretion of the administrative law judge to assign weight to x-ray interpretations based on the

[10] A B-reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the United States Department of Health and Human Services. 42 C.F.R. § 37.51. The qualifications of physicians are a matter of public record at the National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. Because B-readers are deemed to have more training and greater expertise in the area of x-ray interpretation for pneumoconiosis, their findings may be given more weight than those of other physicians. Taylor v. Director, OWCP, 9 B.L.R. 1-22 (1986).

readers' qualifications. Goss v. Eastern Associated Coal Co., 7 B.L.R. 1-400 (1984); Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32 (1985) (granting great weight to a B-reader); Roberts v. Bethlehem Mines Corp., 8 B.L.R. 1-211, 1-213 n. 5 (1985) (granting even greater weight to a Board-certified radiologist). In this case, the one x-ray was interpreted in opposition by equally, highly qualified physicians.

Ultimately, one x-ray stands in equipoise. (MDX 14; MEX 1). I find that the Claimant has not established the existence of pneumoconiosis, by a preponderance of evidence, pursuant to Section 718.202(a)(1).

Pursuant to Section 718.202(a)(2), pneumoconiosis may be established by biopsy or autopsy evidence. On the Claimant's black lung evidence summary form, she indicated Dr. Hanke's autopsy February 17, 2002 autopsy report. Dr. Hanke's autopsy included both gross and microscopic findings. In his microscopic findings, Dr. Hanke listed "[s]ections of all lobes of both lungs have advanced, diffuse honeycomb fibrosis characteristic of end-stage lung disease, cause not determined. Coal dust macules and coal nodules are not identified.... The pulmonary hilar lymph nodes bilaterally have focal fibrosis." Dr. Hanke's final autopsy diagnosis was "end stage fibrosis of [the] lungs."

Furthermore, the Employer listed two autopsy reports on its black lung evidence summary form. The evidentiary limitations only allow one autopsy per party. See § 725.414(a)(3)(i). Because the Employer exceeded the limitations, I will consider only the most recent autopsy report. In Dr. Naeye's June 8, 2003 report set forth above, he considered the Miner's autopsy slides as well as medical information and consultative reports from Drs. Canonico, Sargent, Schulttenover, Addelston, Traughber, Taylor, Gallo, Baek, Abramowitz, Binns, Goldstein, Branscomb, Fino, Wheeler, Lancaster, Hanke, Davis, Caffrey, and Hansbarger. He also examined depositions from Drs. Taylor, Caffrey, Dahhan, Fino, and Branscomb. His final conclusion included reference to the autopsy slides and objective medical reports. Therefore, Dr. Naeye's opinion cannot be divided into autopsy and clinical findings. Thus, I find that Dr. Naeye's determinations qualify as a medical report under § 718.201(a)(4)[11] and not as biopsy evidence under this section. See Tapley v. Bethenergy Mines, Inc., BRB No. 04-0790 BLA (May 26, 2005). Accordingly, the

[11] Although this report qualifies as a medical report under § 718.201(a)(4), the report would exceed the limitations under that section.

Claimant has not established the Miner had pneumoconiosis per § 718.202(a)(2).

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in Sections 718.304, 718.305, or 718.306 are applicable. Section 718.304 is not applicable in this case because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, Section 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

The fourth and final way to establish the existence of pneumoconiosis is set forth in Section 718.202(a)(4). This subsection provides for such a finding where a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis. Any such finding shall be based upon objective medical evidence and shall be supported by a reasoned medical opinion. A reasoned medical opinion is one which contains underlying documentation adequate to support the physician's conclusions. Field v. Island Creek Coal Co., 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id.

Treatment notes from St. Thomas Medical Group were submitted into evidence. (WDX 11). The Miner was treated from October 6, 1999 to September 28, 2001. Physical examinations showed diffuse lung crackles, and a CT scan showed mild enlargement of the mediastinal nodes and right hilar adenopathy with severe interstitial pulmonary fibrosis with honeycombing. Pulmonary function studies were essentially normal. Cytology reports were normal also. Numerous x-rays were taken and showed very little change in condition; however, these x-rays readings were not attached. Various diagnoses for the Miner included interstitial pulmonary fibrosis secondary to occupational exposure followed by end-stage interstitial pulmonary fibrosis, hypoxemia, cystic fibrosis, obesity, and bronchitis. The remainder of the findings in the treatment notes do not relate to Miner's respiratory or pulmonary condition. The physicians who made diagnoses listed in these treatment notes did not expressly state the medical evidence that they relied on in making their determinations. Therefore, I find the diagnoses in the treatment notes form St. Thomas Medical Group are unreasoned.

Hospital records form St. Thomas Hospital dating from December 7, 2001 to December 10, 2001 were offered into evidence. (WDX 11). In the admitting report, Dr. Canonico noted the Miner quit smoking forty years earlier and had not worked in the coal mining industry for thirty years. A chest examination showed diffuse bilateral crackles with the lower lobes greater than the upper lobes and the left greater than the right. Dr. Canonico's impression was interstitial pulmonary fibrosis, worsening hypoxemia, shortness of breath, and episodes of hemoptysis. Due to the Miner's chest x-ray and off-colored sputum, Dr. Canonico opined the Miner could have a pneumonic process superimposed on his interstitial fibrosis. He admitted the Miner to the hospital for evaluation. Cytology reports and a bronchoscopy were normal.

The Miner was treated at Regional Medical Center on February 17, 2002. (WDX 11). Several of the treatment notes were illegible; however, Dr. Hanke noted that the Miner had end-stage pulmonary fibrosis and was terminal. Later in the day, the Miner died, and in a death summary, Dr. Hanke listed the cause of death as pulmonary fibrosis. He also performed an autopsy which was addressed in § 718.202(a)(2).

In a letter to the Claimant's attorney dated April 23, 2003, Dr. Canonico stated that his consistent pulmonary diagnosis was interstitial pulmonary fibrosis caused by the Miner's occupational exposure to coal and rock dust over a period of fifteen years. (MCX 9).[12] Specifically, Dr. Canonico

---

[12] The Claimant listed Dr. Canonico's March 25, 2005 medical report as rebuttal evidence for Dr. Fino's May 6, 2003 medical report. However, the regulations state:

> The Claimant shall be entitled to submit, in rebuttal of the case presented by the claimant, no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by the responsible operator under paragraph (a)(2)(i) of this section and by the Director pursuant to Sec. 725.406.

§ 725.414(a)(2)(ii) (2001).

stated that he relied on chest x-rays, breathing tests, and CT scans which all indicated pulmonary fibrosis. He was able to make this determination because mixed connective tissues were negative, there were no physical presentations for another possibility, and he was the wrong age and gender to develop idiopathic pulmonary fibrosis. Thus, given his coal dust exposure and lack of any smoking history for the past several years, Dr. Canonico attributed the disease to his occupational history. In conclusion, Dr. Canonico opined the Miner suffered from a chronic lung disease primarily caused by his fifteen years of exposure, and he was able to reach this conclusion with an autopsy report showing clinical pneumoconiosis.[13] However, Dr. Canonico did not state which autopsy report that he relied on in forming his opinion. Furthermore, he failed to expressly list or attach the x-rays, breathing tests, and CT scans that he referred to in his report. As no additional treatment records from Dr. Canonico outside of St. Thomas Hospital records were offered in the widow's claim, I find Dr. Canonico's April 23, 2003 letter is undocumented and entitled to less weight in this section.

Dr. Traughber's opined that the Miner had category 1/1 pneumoconiosis and a restrictive ventilatory deficit due to coal dust exposure. (MDX 14). Dr. Traughber based his findings on a positive x-ray, a pulmonary function study that was invalidated, symptomatology, and coal mine and smoking histories consistent with Judge Mosser's findings. As noted by Judge Mosser, I find Dr. Traughber's report is well-reasoned and well-documented and entitled to probative weight.

The Employer listed four medical reports on its black lung evidence summary form. The regulations allow the responsible operator to submit two initial medical reports. See § 725.414(a)(3)(i). As the Employer has exceeded these limitations, I will only consider the two most recent medical reports from Drs. Branscomb dated June 26, 2003 and Dr. Fino dated March 28, 2003. Furthermore, the Employer listed Dr.

As the regulations do not expressly provide for rebuttal evidence to a medical report, Dr. Canonico's March 25, 2005 medical report will not be considered herein.

[13] The Claimant indicated on her black lung evidence summary form that that Dr. Canonico's August 21, 2003 deposition was to be considered. However, his deposition was not submitted into the record at the hearings conducted by Judges Kane and Hillyard. Therefore, I will not consider it herein.

Fino's April 1, 2005 medical report as rebuttal evidence. As noted above, the regulations at § 725.414(a)(3)(ii) do not expressly state that a party is allowed rebuttal evidence to medical reports. Therefore, Dr. Fino's April 1, 2005 rebuttal medical report will not be reviewed herein.

Dr. Fino, Board-certified in Internal Medicine and Pulmonary Diseases, prepared a consultative report on March 28, 2003. (MEX 5). He reviewed x-ray interpretations by Drs. Branscomb, Kendall, Dahhan, Wheeler, Baker, Canonico, Barrett, Goldstien, Sargent, Traughber, Abramowitz, Baek, Binns, and Taylor; clinic treatment notes from January 5, 1999 to September 2, 1999; an August 14, 1998 CT scan; Dr. Canonico's September 17, 1999 medical letter; Dr. Taylor's September 249, 1999 medical letter; Dr. Branscomb's October 4, 1999 medical report; Dr. Dahhan's October 5, 1999 medical report; Dr. Caffrey's February 19, 2000 pathology report; Dr. Hansbarger's February 29, 2000 pathology report; depositions from Drs. Branscomb, Fino, Dahhan, Caffrey, Taylor; Dr. Taylor's March 27, 2000 questionnaire; cytology reports; Dr. Canonico's February 7, 2002 progress note; the Miner's death certificate; and Dr. Caffrey's August 27, 2002 medical report. From this evidence, Dr. Fino opined the Miner did not have clinical pneumoconiosis as shown through pathology reports. However, Dr. Fino did diagnose the Miner with idiopathic interstitial pulmonary fibrosis. He stated that this disease was not contributed to or caused by coal dust exposure as shown by no advanced silicosis or heavy anthracotic dust deposition in the lungs. He explained that the Miner's exact cause of death was unknown because the autopsy was limited to the lungs.

In a supplemental report dated May 6, 2003, Dr. Fino reviewed Dr. Canonico's April 23, 2003 medical report. (MEX 8). He specifically stated that there was no objective evidence of a respiratory impairment. Furthermore, Dr. Fino explained Dr. Canonico's statements that the Miner is the wrong age and gender to develop idiopathic pulmonary fibrosis are incorrect.

Dr. Ben Branscomb, Board-certified in Internal Medicine, prepared a consultative medical report dated June 26, 2003. (MEX 11). He reviewed his prior October 4, 1999 report; Dr. Taylor's October 9, 1998 medical report; 1999 medical reports from Drs. Fino and Dahhan; Dr. Canonico's September 17, 1999 medical letter; Dr. Taylor's September 24, 1999 treatment notes; Dr. Hansbarger's February 29, 2000 report; Dr. Caffrey's February 19, 2000 medical report; Dr. Taylor's March 27, 2000 medical report; Dr. Canonico's December 10, 2001 treatment records;

hospital records from St. Thomas Hospital and Dr. Lancaster; the Miner's death certificate; Regional Medical Center hospital records from Dr. Hanke dated February 17, 2002; Dr. Bauer's autopsy report; Dr. Caffrey's August 27, 2002 consultative report; Dr. Dahhan's April 11, 2003 deposition; Dr. Canonico's April 23, 2003 medical letter; pulmonary function studies contained in the medical reports; and x-ray interpretations from himself, Fino, Wheeler, Kendall, Dahhan, and Baker.

After studying the records, Dr. Branscomb found that the Miner did not have medical pneumoconiosis as shown by autopsy findings. (MEX 11). Furthermore, he stated that the pulmonary function studies and the autopsy evidence do not support a finding of chronic obstructive pulmonary disease or any obstructive disease. He explained that there was no basis for finding legal pneumoconiosis because the Miner did not have a pulmonary condition caused, irritated by, or any way aggravated by coal mine dust. However, Dr. Branscomb did diagnose the Miner with idiopathic diffuse interstitial fibrosis without any relation to his coal dust exposure.

In Church v. Kentland-Elkhorn Coal Corp., BRB Nos. 04-0617 BLA and 04-0617 BLA-A (Apr. 8, 2005) (unpub.), the Board held that medical evidence submitted in a living miner's claim is not automatically admissible in a survivor's claim filed after January 19, 2001 and stated the following:

> As noted by the Director, when a living miner files a subsequent claim, all evidence from the first miner's claim is specifically made part of the record. See 20 C.F.R. § 725.309(d). Such an inclusion is not automatically available in a survivor's claim filed pursuant to the revised regulations. As this case involves a survivor's claim, the medical evidence from the prior living miner's claim must have been designated as evidence by one of the parties in order for it to have been included in the record relevant to the survivor's claim.

Id.

The Board concluded that the medical evidence from the living miner's claim must meet the limitations under 20 C.F.R. § 725.414 to be considered in the survivor's claim and medical

opinion evidence in the survivor's claim should consider only evidence that is properly admitted. As the majority of records that Drs. Branscomb and Fino reviewed in their medical reports were not indicated on either parties' Black Lung Evidence Summary forms, these reports consider evidence in excess of the evidentiary limitations in the widow's claim. Because their medical reports do not comply with the evidentiary limitations, I will not consider them herein.[14]

Accordingly, I rely on Dr. Traughber's opinion, the only well-reasoned and well-documented report in the widow's claim, to find that the Claimant has established by a preponderance of evidence that the Miner had clinical pneumoconiosis under § 718.202(a)(4).

Arising Out of Coal Mine Employment:

Next, the Claimant must establish that the Miner's pneumoconiosis arose, at least in part out of coal mine employment. § 718.203(a). It is presumed that pneumoconiosis of a Miner who establishes ten or more years of coal mine employment arose out of coal mine employment. Id. As the parties stipulated that the Miner had eleven years of coal mine employment, I find the Claimant is entitled to the presumption. Thus, the Claimant has prove that the Miner's pneumoconiosis arose from coal mine employment as required under § 718.203(a).

Death Due to Pneumoconiosis:

Pursuant to § 718.205(c), the Claimant must establish that the Miner's death was due to pneumoconiosis. The United States Court of Appeals for the Sixth Circuit has held that any condition that hastens death is a substantially contributing cause of death for purposes of § 718.205. Brown v. Rock Creek Mining Corp., 996 F.2d 812 (6th Cir. 1993); Griffith v. Director, OWCP, 49 F.3d 184 (6th Cir. 1995). This element of entitlement is established by well-reasoned and well-documented medical opinions.

The record in the widow's claim contains one well-reasoned and well-documented medical report regarding pneumoconiosis was

[14] I note that if I examined the two other reports from Drs. Broudy and Dahhan that were listed in excess of the evidentiary limitations on the Employer's black lung evidence summary form that they also consider evidence that exceeds the limitations in the widow's claim.

from Dr. Traughber. (MDX 14). However, he did not list a cause of death because at the time of his report the Miner was still living.

Furthermore, the only additional medical evidence addressing the issue of causation in the Miner's death that did not exceed the evidentiary limitations or was unreasoned or undocumented was the hospital records from Regional Medical Center on February 17, 2002. (WDX 11). Dr. Hanke listed the Miner's cause of death as pulmonary fibrosis. He did not list an etiology for the disease.

Accordingly, the record does not contain any well-documented and well-reasoned evidence supporting a finding that the Miner's death was hastened by pneumoconiosis. Accordingly, death due to pneumoconiosis has not been established pursuant to § 718.205(c).

Entitlement:

As the Claimant, Debra Patterson, has failed to establish the Miner's death was due to pneumoconiosis, she is not entitled to benefits under the Act.

As the Miner, Alvie Patterson, has failed to establish pneumoconiosis, total disability, and total disability arising out of pneumoconiosis, he is not entitled to benefits under the Act.

Attorney's Fees:

The award of an attorney's fee under the Act is permitted only in cases in which the Claimant is found to be entitled to the receipt of benefits. Because benefits are not awarded in these cases, the Act prohibits the charging of any attorney's fees to the Claimants for legal services rendered in pursuit of benefits.

ORDER

It is thereby ORDERED that the claim of ALVIE PATTEROSN for benefits is hereby DENIED. It is further ORDERED that the claim of DEBRA PATTERSON for benefits is DENIED.

A

DANIEL J. ROKETENETZ
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the District Director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).